APPEAL NO. 021881
FILED SEPTEMBER 16, 2002

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. Section 401.001 *et seq.* (1989 Act). A contested case hearing (CCH) was held on September 6, 2001. The hearing officer determined that the respondent's (claimant) injury included a cervical herniated disc at C4/5.

The case had been remanded in Texas Workers' Compensation Commission Appeal No. 012400, decided November 28, 2001, after the hearing officer initially found that he had no jurisdiction to consider the extent issue because a decision authorizing spinal surgery had already been made.

The appellant (self-insured) appeals the determination on the merits and further argues that the hearing officer abused his discretion by not granting a motion to abate this proceeding pending the matter in court. Referencing many documents ostensibly on file with the Texas Workers' Compensation Commission (Commission), but not made part of the record in either proceeding on this matter, the self-insured says it is entitled to an abatement because it was wrongfully deprived of the opportunity to do pertinent discovery due to an abuse of discretion by the hearing officer. The self-insured asks the Appeals Panel to take official notice of the stage of proceedings in the district court. Finally, the self-insured assails the credibility of the evidence offered as to the extent of injury. There is no response from the claimant.

DECISION

We affirm the hearing officer's decision.

The claimant was injured on _____, while employed by the self-insured, when he pushed and pulled on a lift that was stuck but suddenly lurched free. The accident was promptly reported to the claimant's supervisor, who testified that when he investigated the scene he noted a large amount of paint buildup on the rails of the lift device. Although the initial diagnosis was cervical sprain and shoulder injury, an MRI taken on March 28, 2001, showed a herniated cervical disc. The claimant's treating chiropractor referred him for evaluation and surgery was recommended. The self-insured's second opinion doctor agreed with the need for surgery.

On (date of a previous injury), the claimant had been involved in a motor vehicle accident (MVA) in which his car was struck from behind. Medical records for treatment of that injury identify the lumbar area as primarily affected, although he also had upper arm pain at first and indicators of a cervical sprain. He was released back to regular duty work on December 6, 1999, and did not see his doctor again until his _____ injury. The claimant said that soreness in his neck and upper arm area went away after a couple of days and his lower back remained the main area of pain. He said that he had asked his treating chiropractor to send the self-insured all the information pertaining

to his MVA, and the evidence presented by the self-insured concerning that accident appears responsive to the request. The treating chiropractor stated that the claimant's cervical symptoms after the MVA were so mild that he did not have cervical x-rays performed although lumber x-rays were taken. He explained why he did not regard these symptoms as a similar injury to the one he diagnosed in _____.

THE HEARING OFFICER'S DENIAL OF DISCOVERY MOTIONS

Because the self-insured apparently regarded the Appeals Panel's previous decision concerning denial of discovery motions as a "final decision," and took the matter to court even though the matter was remanded back to the hearing officer, we will expand upon our previous decision here on the matter of any preliminary motions that may have been denied by the hearing officer. The fact that the self-insured characterizes the previous Appeals Panel decision on discovery motions as inconsistent with its determination on the hearing officer's jurisdictional holding reflects an erroneous belief that the Appeals Panel examined all documents filed with the Commission, whether or not they were part of the record. Such is not the case.

In fact, the previous decision of the Appeals Panel was that "[t]he record did not establish that the hearing officer acted without reference to any guiding rules and principles in denying the motions." The burden is on the party asserting an abuse of discretion to establish this in order to preserve error. *See* Texas Workers' Compensation Commission Appeal No. 000832, decided June 2, 2000.

The primary reason that the record then, or now, does not "establish" an abuse of discretion by the hearing officer by denial of any preliminary matters is that the self-insured failed, in either proceeding, to make any such preliminary motions and rulings thereon a part of the record. It has not preserved error *in either proceeding* regarding denial of discovery. No official notice was requested of any such motions nor was any document thereof made part of the record. The self-insured did not urge a motion for continuance at the first session of the CCH (a matter acknowledged in its first appeal). In its first appeal, the self-insured did not assert that the basis for any evidentiary rulings was the hearing officer's position that he lacked jurisdiction to consider the extent of injury.

At the second session of the CCH, the self-insured asked only to abate the CCH pending the outcome of its interlocutory appeal, and did not seek a review of the previously-urged discovery motions, although it argued (for the first time) that the basis for a denial of some of these may have been similar to the reason that the Appeals Panel remanded the case.

There was only generalized discussion of a Motion for Continuance and other motions at the beginning of the original session of the CCH. The hearing officer's suggestion to reurge those motions at the end of the CCH never materialized. Consequently, the record fails to support any abuse of discretion by the hearing officer because it fails to demonstrate what was sought and when. The self-insured did not

make the case that any information it sought could be obtained only through discovery or subpoenas or had not already been obtained.

The self-insured is in a position largely because of the consequences of its own actions. It did not undertake to dispute the compensability of the claimant's cervical injury until after surgery was recommended, filing the Payment of Compensation or Notice of Refused/Disputed Claim (TWCC-21) two months after the injury, after the second opinion process was underway. The duty to investigate a claim arises from inception of written notice of injury, received, according to the TWCC-21, on March 19, 2001.

We would observe that, to the extent such discovery sought the claimant's medical records, the self-insured as the payer of the medical billings should have been able to obtain the claimant's medical records and back-up support from the servicing company who handles its workers' compensation adjusting services. With respect to records involving the MVA, it became clear during the cross-examination of the chiropractor that he had produced such records in response to a request for those records. It is clear from some of the chiropractor's answers that he was surprised, from argumentative cross-examination, that the self-insured's attorney did not have some of the records relating to the 2001 injury. The relevance of any broad-based inquiry into the claimant's entire medical history was not asserted except for the self-insured's contention that the severity of the claimant's injury was not explained by the mechanics of the _____, accident. The record does not include any indication that the self-insured availed itself of the right to have the claimant examined in a required medical examination by a doctor of its own choice.

Finally, the motion to abate indicates that some of the denied motions were repeated requests for depositions of the claimant, triggered in part because claimant's answers to interrogatories were apparently insufficiently complete for the self-insured. It is unclear from the record why a deposition of the claimant would be required in addition to his statement given to the adjuster and his sworn testimony at the CCH, especially in light of the fact that the self-insured did not dispute that an accident had happened.

Much of the self-insured's argument that it was "ambushed" go to the weight and credibility that it argues should not have been accorded to the claimant's or chiropractor's testimony. The transcript shows that the self-insured was afforded (and availed itself of) the full opportunity to cross-examine the claimant and his chiropractor about the claimant's prior MVA injury. Medical records concerning the MVA injury were among the self-insured's own exhibits. Obviously, in order to file a good-faith dispute of the claim, it had information concerning the MVA.

The hearing officer had the opportunity to observe the demeanor of both witnesses and consider the records submitted. Furthermore, the self-insured's insistence on "complete information" before paying the claim may be based in part on a misunderstanding of the applicable law--for example, it argued that if the chiropractor's treatment of the claimant's neck injury "caused" the cervical herniation, it would not be

liable. The chiropractor was questioned at length about the types of manipulations he did and amount of force used. However, injuries that occur during the medical treatment of a compensable injury become part of that injury. See Texas Workers' Compensation Commission Appeal No. 92538, decided November 25, 1992; Texas Workers Compenastion Appeal No. 92540 (citing Texas Employers Indemnity Company v. Etie, 754 S.W.2d 806 (Tex. App.-Houston [1st Dist.] 1988, no writ)). A quest for some chart notes by the chiropractor to assess his causal role would thus have little to do with the compensability of the injury.

For these reasons, we reiterate that the record does not show that the hearing officer abused his discretion if he disallowed some discovery prior to the CCH.

REFUSAL OF THE HEARING OFFICER TO ABATE THE REMAND HEARING

Based upon its interlocutory appeal of the remand decision of the Appeals Panel, the self-insured sought an abatement of any further hearing on this matter pending the outcome of the district court case. (We clerically correct the remand decision to reflect that the Motion to Abate was admitted at the CCH as Self-insured's Exhibit No. 30). The motion to abate was presented at the remand session of the CCH and made part of the record; the rationale advanced in argument was that the Appeals Panel decision, concerning the determination that the record did not demonstrate an abuse of discretion in denial of preliminary matters, was a "final decision on the point of appeal." However, the hearing officer announced that he would take this motion "under advisement." There is no ruling on the record, but the decision for this January 2002 session was not written until June 28, 2002.

Although we are unable to conclude that the proceeding was not in some respects abated, we note that the previous Appeals Panel decision expressly stated that it was not a final decision. The self-insured's appeal to district was therefore premature because it did not exhaust its remedies in accordance with Section 410.251. There is no authority for interlocutory appeals on procedural matters to the district court, let alone authority to abate benefits issues pending such procedural appeals. The hearing officer was not compelled because of this interlocutory decision to suspend, at continuing hardship to the claimant, any adjudication on the merits of his injury. The appeal complains that the self-insured could have produced, if allowed to do so, additional expert testimony favorable to its case. However, the hearing officer asked the self-insured at the remand session if it had additional evidence to produce and the self-insured said it did not.

We find no merit in the appellate point regarding the motion for abatement.

EXTENT OF INJURY

A claimant's testimony alone, when believed, may establish that an injury has occurred, and disability has resulted from it. Houston Independent School District v. Harrison, 744 S.W.2d 298, 299 (Tex. App.- Houston [1st Dist.] 1987, no writ). Expert

medical evidence was not required to prove the occurrence of a cervical injury. We would caution that while chronology alone does not establish a causal connection between an accident and a later-diagnosed injury (Texas Workers' Compensation Commission Appeal No. 94231, decided April 8, 1994), neither does a delayed manifestation nor the failure to immediately mention an injury to a health care provider necessarily rule out a connection. *See* Texas Employers Insurance Company v. Stephenson, 496 S.W.2d 184 (Tex. Civ. App.-Amarillo 1973, no writ). Generally, lay testimony establishing a sequence of events, which provides a strong, logically traceable connection between the event and the condition, is sufficient proof of causation. Morgan v. Compugraphic Corp., 675 S.W.2d 729, 733 (Tex. 1984).

The fact that the claimant may have had a preexisting residue of his MVA does not forseclose the self-insured's liability. It is axiomatic, in case law having to do with aggravation, that the employer accepts the employee as he is when he enters employment. Gill v. Transamerica Insurance Company, 417 S.W.2d 720, 723 (Tex. Civ. App.-Dallas 1967, no writ). An incident may indeed cause injury where there is preexisting infirmity where no injury might result in a sound employee, and a predisposing bodily infirmity will not preclude compensation. Sowell v. Travelers Insurance Company, 374 S.W.2d 412 (Tex. 1963). However, the compensable injury includes these enhanced effects, and, unless a first condition is one for which compensation is payable under the act, a subsequent appellant's (carrier) liability is not reduced by reason of the prior condition. St. Paul Fire & Marine Insurance Company v. Murphree, 357 S.W.2d 744 (Tex. 1962).

In considering all the evidence in the record, we cannot agree that the findings of the hearing officer are so against the great weight and preponderance of the evidence as to be manifestly wrong and unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951). We affirm the decision and order, adding only the clerical correction that the list of exhibits includes Self-insured's Exhibit No. 30, the Motion to Abate (and attachments thereto).

The true corporate name of the insurance carrier is **UNION TANK CAR COMPANY** and the name and address of its registered agent for service of process is

U.S. CORPORATION SERVICE
800 BRAZOS STREET
AUSTIN, TEXAS 78701.

_____
Susan M. Kelley
Appeals Judge

CONCUR:

_____
Gary L. Kilgore
Appeals Judge

_____
Robert W. Potts
Appeals Judge